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ABSTRACT

This chapter discusses adolescent drug abuse relapse prevention. It presents the following four conclusions regarding the efficacy of prevention programs. First, more controlled studies are needed to evaluate the long-term effectiveness of relapse prevention strategies with adolescents in reducing factors such as cravings and increasing their ability for self-assessment, monitoring, self-control, and maintenance of abstinence behaviors. Secondly, studies are also needed to examine posttreatment predictors of relapse. In order to accomplish this, well-designed comparison groups must be utilized in studying the effectiveness of relapse prevention strategies. Thirdly, some degree of consensus regarding standard definitions would enhance the comparability of studies. Finally, although there is a heightened awareness of the importance of relapse prevention, there is substantial lack of coordinated attempts to deal with the problem of relapse among adolescents. Overall success of prevention programs will ultimately depend on a well-orchestrated coordination among families, schools, communities, treatment centers, support groups, and social institutions. Also included is a facilitator's manual which is a practical guide for teaching content through guided experiential projects. Six objectives and six student exercises are provided. (Contains 57 references.) (MKA)

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Preventing Adolescent Relapse: Concepts, Theories and Techniques

Shitala P. Mishra & Robert A. Ressler

Introduction

It is now broadly acknowledged by many that drug and alcohol addiction is a disease and, as in the case with many diseases, there is a likelihood of relapse, the returning to abuse of the substance after treatment. Thus, relapse is a major concern for professionals providing drug abuse treatments to individuals suffering from alcohol and drug dependency. Individuals with substance abuse problems have a pattern of trying to stop using drugs, alcohol, or both several times before receiving treatment and have difficulty doing so. The literature seems to indicate that the highest probability of relapse occurs during the first two years of recovery (Talbott & Martin, 1999), a process of healing that results from abstinence and participation in a treatment program. Since the relapse is a typical occurance in drug dependence, it is important to understand the factors that trigger compulsive tendencies to resume the use of drugs and alcohol.

Relapse Defined

Although there are varied definitions of relapse, it essentially involves the resumption of mood altering drug usage following a period of recovery. It usually occurs early in the recovery process. About two-third of adults show relapse tendencies within 90 days of discharge from treatment facilities. Relapse requiring posttreatment ranges from 35 to 85 % among addicts exposed to treatments (Catalano, Hawkins, Wells, Miller, & Brewer, 1991).

In general, the relapse occurs primarily due to an individual's inability to cope with life in sobriety or without drugs. The literature suggests there are possibly two ways to look at the relapse phenomenon. The relapse can be understood as a discrete event occurring with a single use of a drug (Wesson, Havassy, & Smith, 1986). In a discrete event type relapse, the distinction is made between the first use of the individual's primary drug of abuse and first use of any other psychoactive drug. Return to the primary drug presents the most likelihood of returning to abuse (Hubbard & Marsden, 1986). From a process perspective, an individual's addiction can be viewed as a process developing over time, with relapse conceptualized in a number of ways. Relapse can be defined as daily drug use for a specified period; as a return to the pretreatment baseline level; or as return to drug use levels above specified criterion of quantity and /or duration of drug usage (American Psychiatric Association *DSM-IV*, 1994).

Causes and Etiology of Relapse

The factors contributing to relapse may range from socioeconomic and ethnic status of an individual to chronic history of substance abuse. Individuals who abuse drugs often have been found to come from low socioeconomic status (SES) homes, have a chronic history of drug abuse, exhibit poor symptoms of mental health, possess inadequate skills to cope with social pressure, and often have sporadic patterns of involvement in substance abuse treatment programs. Talbott and Martin (1999) report potential factors that contribute to relapse. These are failure to understand/accept drug dependency, denial of loss of control, emotional concealment, extensive rationalization, dysfunctional family, lack of access to spiritual program, stress, isolation, cross addiction, holiday syndrome, withdrawal, overconfidence, returning to drinking friends, and guilt over the past. Many personality factors such as comorbidity, high stress personality, and low impulse control ability have also been found in relapse prone addicts. The influence of familial environment on possibility of relapse has also been found to be quite strong. Individuals experiencing parental separation, loss of family members, and break up of family relationships have shown stronger tendencies to resume to drug use behaviors after the recovery period (Talbott & Martin, 1999). DeJong and Henrich (1980) in a study utilizing samples of adolescents and young adults found three correlates of posttreatment relapse. First, thoughts and feelings about drugs and drug cravings were found to be related to relapse. In contrast to relapsers, these thoughts and feelings decreased more in nonrelapsers than in relapsers at one year posttreatment follow-up. A second finding is that relapsers are much less involved in productive activities including school work. Relapsers were also found to have fewer

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and less satisfying leisure activities. Similar findings related to posttreatment factors such as drug craving, low involvement in productive and leisure activities were found to be strong predictors of relapse among adult drug abusers by Catalano, Howard, Hawkins, and Wells (1988). The implications of such findings would seem to suggest the importance of cognitive and behavioral skills training to reduce cravings and increase social skills for reducing relapse.

Drug Abuse, Relapse, and Psychological Development

In the early 1900's, G. Stanley Hall (1904) first promoted the study of the psychology of adolescence. Hall identified adolescence as the period from puberty until full adult status. He characterized it as a period of *Sturm und Drang*, "storm and stress." In general, he considers the emotional plight of the adolescent to be filled with contradiction. Consistent with this thinking, Kurt Lewin's (1939) field theory approach to adolescence characterizes the adolescent as having a "marginal man" status. This assumes that the adolescent no longer belongs to the social group of children and does not want to be considered a child; yet he is not yet accepted into the social group of adults. Consequently, the adolescent's behavior will reflect this marginality. Numerous other approaches describe the developmental period of adolescence in a similar way. Psychodynamic (Blos, 1979; Freud, 1935; Erickson, 1950), humanistic (Adler, 1930; Rogers, 1931), cognitive (Kohlberg & Kramer, 1969; Piaget, 1968; Thornburg, 1977), social/ecological (Bronfenbrenner, 1972; Elkind, 1998; Selman, 1980), or sociopolitical (Bowles & Gintis, 1976) approaches all reflect the view that adolescence is a period of marked stress and crisis.

As the adolescent attempts to establish their identity and independence, he/she will begin to explore a variety of behaviors and attitudes (Thornburg, 1977). This explanation is an important factor in understanding the use of drugs and alcohol by our society's youth. Several researchers (Hawkins, Catalano, & Miller, 1992; Norman, Turner, Zunz, & Stillson, 1997) suggest that the various developmental domains in adolescence, including physical, emotional, psychological, social, and cognitive, lead to potential risk-factors for drug and alcohol use/abuse. Evidently, there is a strong relationship between the specific problems associated with adolescent development and the general potential for drug/alcohol use/abuse.

Jessor (1985), who contends that there are four fundamental explanations for adolescent drug and alcohol use, addresses the relationship between adolescent development and drug/alcohol use. First, it appears that drugs and alcohol provide adolescents with a means to relieve feelings of inadequacy and other psychological pains that naturally occur during adolescence (e.g., boredom and loneliness). Drug and alcohol use also offers an opportunity for the adolescent to express opposition to authority. It affirms solidarity patterns with peers, and makes teens feel "grown up" while marking the transition from the inferiority of childhood to the superiority of adulthood.

There are several societal factors which impact adolescent drug and alcohol use. Our society today is more violent and alienating than in the past. The prevalence of abuse, both physical and sexual, and neglect appear to be at significantly high levels (Winzer, 1993). Other problems associated with gangs and gang violence greatly impact our youth (Branch, 1999), and the number of runaway, thrown-away, and homeless youth is growing and constitutes a major social dilemma (Kryder-Coe, Salamon, & Molnar, 1991). In addition, glamorized images of drug use in our media, political ineffectiveness, and economic inadequacies must not be taken lightly for they impact adolescent behaviors tremendously (see for example, Bowles & Gintis, 1976; Gerbner, 1990; Gitlin, 1990).

Hawkins, Catalano, & Miller (1992) conducted an extensive investigation of specific risk factors for adolescent drug and alcohol abuse. The authors identify two categories of factors, contextual (societal and cultural), and individual and interpersonal (physiological, family, school, classrooms, and peer groups). Contextual factors impacting drug and alcohol use include things such as laws and norms, availability of drugs and alcohol, extreme economic deprivation, and neighborhood disorganization. Individual and interpersonal risk factors include the child's level of alienation from the dominant values of school and community, high tolerance level for deviant behaviors and normlessness, high resistance to traditional authority, sensation seeking, little concern for safety, poor school performance, and association with peers who use drugs.

The interpersonal factor that appears to have a great impact on reducing the risk of drug and alcohol use involves the parent-child relationship. Parents who have a close relationship with their children and are involved in a positive way with their children's activities decrease risk factors for drug and alcohol use and abuse (Hawkins, et al. 1992). Hawkins, et al. (1992) also emphasize that further research is necessary to determine the interaction effects among the contextual and individual and interpersonal risk factors, which of these factors are modifiable,

and which are specific to drug abuse rather than generic contributors to adolescent problem behaviors.

A study of drug and alcohol behaviors by Bennett (1983) identifies three main patterns of consumption:

(1) experimentation,
(2) episodic, and
(3) addictive or compulsive.

The prominent variable in this classification approach is frequency of use. In reference to this issue, one study conducted by Shedler & Block (1990) provides a look at the relationship between personality and consumption patterns. The authors suggest that there are similar personality traits between the frequent users and those who abstained until the late teen years. They report that those individuals who were the most anxious and had the poorest social skills and most restricted personalities were those who had abstained from drugs and alcohol through the age of eighteen. Those who were the most maladjusted and alienated and who had poor impulse control and the highest levels of emotional stress were the frequent users. It is interesting to note that those who were the 'best adjusted' were the experimenters (Shedler & Block, 1990). Factors contributing to relapse that have frequently appeared in the literature (Bennet, 1983; Catalano et al. 1991; Gorsky & Miller, 1986; Talbott & Martin, 1999) are summarized in the following table.

Table I: Factors Contributing to Relapse

Personality Factors	Family	Social/Cultural	Personal Skills
Feelings of alienation	Stressful parent-child relationship	Lack of support system	Inadequate coping skills to deal with social pressures
Poor inability for impulse control	Divorced parents	Moving away from friends	Inability to deal with interpersonal conflicts
High stress personality	Substance use in the home	Break up of relationships between girlfriend/wife	Harboring negative emotions
Inability to control anxiety and anger	Dysfunctional family structure	Frequent school change	Recurrent thoughts or physical desire to use drugs or alcohol
Depression	Mental illness in parents	Lack of moral, spiritual support	Lack of skills to cope with high risk situations
Denial of drug dependence	Loss or death of family member	Frequent interactions with substance abusing peers	Desires to test personal control over drugs
Reality distortion and emotional concealment	Frequent exposure to physical and/or sexual abuse during developmental years	Inability to avoid substance use during social events (e.g., Thanksgiving, Christmas, birthdays, weddings, etc.)	Denial of loss of control
Thrill-seeking tendencies	Excessive parental absence	Lack of friendships	Inadequate skills to make lifestyle changes
Isolation or withdrawal to avoid conflict and vulnerability to pain	Location of family in high-risk neighborhood	Extreme economic deprivation	Inadequate skills to replace substance use and identify with positive peers
Cross-addictive behaviors	Unemployment	Neighborhood disorganization	Learning Disability
Feelings of guilt over past use	Domestic violence		
Overconfidence	Child neglect		
Defiance to authority			

While discussing the issue of consumption and frequency, Bennett (1983) also addresses the need to distinguish between the concepts of use and abuse. A point of great debate here is whether or not any use of alcohol, drugs, or both by minors should be defined as abuse. According to Norman et al. (1997), simple experimentation of drugs and alcohol is normal behavior for adolescents; whereas, daily use is abusive, dysfunctional behavior. Based on the underlying legal and moralistic implications, any use of illegal substances may be viewed by some as abuse. However, Bennett (1983) emphasizes that, although the term 'use' may imply some degree of acceptance and normality, it should not be interpreted as an attempt to condone teen drug and

alcohol use. Rather, of greater concern is the importance of screening out those youth that may need only education or other less intensive forms of guidance from those who need to be treated in programs for substance abuse.

With regard to the relationship of age and use and its impact on future abuse, Jessor (1985) provides evidence that earlier use is more highly correlated to later abuse. He reports that 50% of the males in his study who initiated drug use before the age of 15 later developed a substance abuse problem. In contrast, 26% of those between 15-17, 17% between 18-24 and 11% of those over the age of 25 later developed substance abuse problems.

Jessor's (1985) findings are of great significance in light of the findings, provided by Norman, et al. (1997), which suggest that the greatest age range of risk of initiation is between 12-15. These authors provide several factors that they believe account for the increase in risk of use. These include the physical changes of puberty, the change from elementary school to middle school, an intense pressure to conform with peers, a growing desire to be independent from parents and authority, the increased availability of substances, and the cognitive awareness that drugs and alcohol can temporarily relieve the psychological pain and turmoil of adolescence. The essential timing of the introduction of prevention programs in the school system prior to the age of twelve would appear pivotal in successfully addressing the relatively higher risk of initiation and the growing presence of a variety of factors leading the young adolescent to drug and alcohol use.

An Overview of Drug Abuse Prevention

A review of the history of drug and alcohol prevention programs in the American school system provides an informative look at the evolution of these program methodologies and the development of a growing empirical knowledge base. Norman et al. (1997) suggest that the late 1960's and early 1970's marked the time when the American high schools were targeted for adolescent prevention efforts. According to the authors, this reflected a response to the liberal drug attitudes of the 1960's and the subsequent high frequency rates of drug and alcohol use among American teens. Some estimates suggest that over 75% of adolescents during this time experimented with some form of drugs or alcohol (Kandel,1978). As the programs were implemented and concurrent prevalence rates were not impacted, the shift from targeting

high school age students to middle and elementary school students was observed.

Silverman (1988) (as cited in Norman et al., 1997) indicates that four main program strategies were developed over the years:

(1) Information-Only,
(2) Alternative Activities,
(3) Competency Enhancement, and
(4) Social Environmental.

As the effectiveness of each program methodology was gauged by observing the subsequent prevalence rates of use among adolescents, modifications were adopted to address the inadequacies of each approach.

The Information-Only approach was based on the premise that educating the youth about the properties of drugs, the potential physical reactions to drugs, the methods of use, and the short and long term social and health consequences of use would lead to a reduction in drug and alcohol use. Successes from this approach were extremely limited. Norman et al., (1997) report that numerous studies conducted on the effectiveness of these programs reveal that they are the "most ineffective" drug prevention programs. In fact, some studies indicate that they actually increased drug and alcohol use among teens (Moskowitz, Schaps, Malvin, & Schaeffer, 1984 (as cited in Norman et al., 1997)).

The Alternative Activities approach was based on the assumption that involving youth in satisfying non-drug-related activities would reduce drug and alcohol prevalence rates. Norman et al., (1997) suggest that the effects were negligible due in large part to the fact that non-use of substances was not incorporated as a focus of the activities. In fact, the authors argue that in some cases drug and alcohol use was increased during exposure to these programs. The type of activity and the settings where they were offered impacted drug and alcohol use. For example, sporting events, entertainment, vocational, and extracurricular activities were associated with higher drug and alcohol use, particularly when individuals who abused substances were present. In contrast, hobbies, academic preparation (tutoring/mentoring), and religious activities were all associated with lower rates of drug and alcohol use.

The rise of the Competency Enhancement approach grew out of the shortcomings of the prior two approaches. This approach emphasized the need to develop self-esteem, appropriate values, decision-making, problem-solving, and/or communications skills. The assumption of this approach was that education and activities alone are not sufficient to counteract the gravitation toward drug and alcohol usage. Adolescents need strong skills and values to face the challenges of adolescence that lead to drug and alcohol use (Norman, et al.1997). The ideals of this approach were well founded; however, their implementation focused on general goals and coping skills. Norman et al. (1997) argue that the limited success of these programs was directly linked to the lack in specificity of teaching substance use prevention strategies.

As the knowledge base for effective prevention program methodologies grew, the development of a more comprehensive and highly focused approach became warranted. The Information-Only, Alternative Activities, and Competency Enhancement strategies each had their own effective components. The development of the Social Environment strategy was an attempt to build on the positive aspects of the previous approaches. It was based on aspects of social learning theory (modeling and imitating non-use behaviors), cognitive or social inoculation theory (inhibiting unwanted substance-using behaviors), and biopsychosocial theory (stressing the important roles and interaction between family, school, and community). The assumption of this approach was that youth can be inoculated against social pressures to use drugs and alcohol by reinforcing social norms against the use of substances and by supplying them with the essential skills to resist the social pressures to use (Norman, et al.1977).

Prevalence of Drug Abuse

Data collected over the past 30 years indicate that overall prevalence rates for drug and alcohol use have declined steadily since the 1970's (National Household Survey on Drug Abuse, 1997). This may reflect both prevention program effects as well as effects from societal shifts in attitude. Norman et al. (1997) suggest that prevalence rates have declined as a result of five major factors:

(1) The fad quality of taking drugs has worn off;
(2) The symbolic value drugs have provided as a form of rebellion has decreased;
(3) The general movement in the U.S. toward more healthy lifestyles has effected adolescents;
(4) Political and professional leaders have taken a firm stance against using drugs; and
(5) Parents, schools, communities, and the media have become more sophisticated in their message about and their programs concerning the non-use of such substances.

Although the overall prevalence rates have dropped, there has been an upward swing in drug use by children between the ages of 12-17 since 1992. In 1979, there was an estimated 16.3% of 12-17 year olds who reported using any illicit drug in the past month. The percentage fell to a low of 5.3% in 1992 and has risen to 11.4% in 1997. A further breakdown of this age group in 1997 reveals that the highest rates were found among young people ages 16-17, where 19.2% report to have used any illicit drug in the past month. Among youth ages 12-13, 3.8% reported use in the past month. Approximately 11.5% of youth ages 14-15 and 17.3% of those between the ages of 18-20 report use in the past month (SAMHSA, 1997).

An analysis of the types of drugs being used reveals that Alcohol (20.5%) and tobacco (19.9%) are the most prevalent for youth between the ages of 12-17. Heavy alcohol use was reported by 3.1% and 'binge' (five or more drinks) alcohol use was reported by 8.3%. Marijuana/Hashish is next with 9.4% reporting use in the past month, followed by inhalants at 2.0%, hallucinogens at 1.9%, and cocaine at 1.0% (SAHMSA, 1997).

The National Institute on Drug Abuse analyzed 8th, 10th, and 12th grade students' daily drug and alcohol use for the years 1991 to 1996 in the Monitoring the Future Study, 1996. In the 1996 sample, daily cigarette smoking was listed as the most prevalent substance of use across all three grade levels. 13.0% of students in 12th grade report daily use followed by 9.4% for 10th graders and 4.3% for 8th graders.

Marijuana/Hashish daily usage rates were the next highest. 4.9%, 3.5%, and 1.5% rates were reported by the 12th, 10th, and 8th graders respectively. Daily alcohol consumption rates followed with 3.7%, 1.6%, and 1.0% of 12th, 10th, and 8th graders. It is interesting to note that when looking at the past 30-day usage rates, alcohol far exceeds all the other substances ranging from a high of 50.8% for 12th graders and a low of 26.2% for the 8th graders. In contrast, 21.9% of 12th graders and 11.3% of 8th graders reported use of marijuana/hashish during the past 30 days. These patterns of consumption behaviors were consistent for all years reported (National Institute on Drug Abuse, Monitoring the Future, 1996).

These data suggest that, when looking at overall usage rates, alcohol is the most widely used substance by

teens. Although, when looking at the daily use of drugs, excluding tobacco, marijuana/hashish is slightly more prevalent than alcohol. A steady decline of drug and alcohol use has occurred from the 1970s - 1990. However, a general increase has occurred during the years 1991-1996 for all usage categories reported; lifetime, annual, 30-day, and daily use of alcohol, tobacco, and marijuana/hashish. In contrast, usage rates for Inhalants, Hallucinogens, LSD, Cocaine, Crack, Heroin, Stimulants, Tranquilizers, and Steroids have remained relatively stable over the same time period.

Etiology

Apparently, drug and alcohol use among teens is quite common and considered a "normal" adolescent behavior. As previously discussed, consumption patterns include simple experimentation, episodic, and compulsive or addictive behaviors (Bennett, 1983). Macdonald (1989) suggests that drug use is not considered maladaptive or dysfunctional until one passes over a line into the area called "drug abuse." He suggests that as the user progresses from curiosity and experimentation to drug addiction he or she passes through recognizable stages where typical behaviors are noted. In the progression from use to addiction, Macdonald (1989) suggests that the five stages include,

(1) curiosity,
(2) learning the mood swing,
(3) seeking the mood swing,
(4) preoccupation with the mood swing and,
(5) doing drugs to feel okay.

The first stage, curiosity, reflects the developmental nature of the adolescent. According to Macdonald (1989), adolescents are more willing to take risks, have a strong need to be accepted by peers, and desire to experience new feelings or mood states. These factors increase the risk of experimentation with drugs and alcohol and elicit a rationalization by the adolescent that "it won't hurt to try one."

Learning the mood swing is the stage in which the adolescent begins to explore the excitement and pleasurable feelings associated with use. Use in this stage tends to occur in social settings among friends or acquaintances who desire to share in the exciting and pleasurable feelings. The most significant aspect of this stage is learning how easy it is to feel good. The euphoric feelings provide the impetus for progressive use patterns. It is important to note that during this stage there are typically very few, if any, consequences experienced by the user, except for moderate levels of guilt. Consequently, there is significant reinforcement for continued usage during this stage (Macdonald, 1989).

In the seeking the mood swing stage, the user is no longer content with waiting for others to provide the drugs or alcohol. It is now important for the user to have his or her own supply of substances. This apparently leads to more frequent use and the beginning of a series of isolating behaviors takes place. The teen in this stage may discontinue activities they have done for years. Hobbies, extra curricular activities, school achievement, and family interaction all seem to decline during this stage. Old non-using friends may be eliminated and a group of new drug-using friends are adopted (Macdonald, 1989).

Planning the day's activities around being high on drugs or alcohol becomes the focus of the user preoccupied with the mood swing. This stage reflects the point at which the user demonstrates psychological dependency. The "need" to rely on drugs for feelings of comfort is emphasized by the user. Further isolation occurs as the user usually has alienated their family, their true friends, and their schools. It is not uncommon for the user in this stage to have jobs, failing grades, run-ins with the law, a break down of sexual inhibitions, and a costly weekly substance habit (Macdonald, 1989).

The final stage in this progression is the point at which drug and alcohol use is the only way to feel okay. The fun, excitement, and euphoria of using are no longer present. The user needs larger dosages, stronger drugs, or both just to function. This stage of dependency leads to further isolation, failures, depression, and suicidal ideations (Macdonald, 1989).

Obviously, not all teens who use drugs and/or alcohol progress through all these stages. Why some experimenters and episodic or recreational users progress to more serious levels of substance abuse is a complicated question to answer. Substance abuse is typically viewed as a chronic, progressive, relapsing disorder resulting in physical and psychological dependence on chemical substances (Crowe & Reeves, 1994). How one develops this state of dependency is not quite clear.

There have been a variety of etiological models, ranging from moral to biopsychosocial, espousing the how's and why's of chemical dependency or addiction (Catalano et. al., 1991; Crowe & Reeves, 1994; Marlatt & Gordon,1985). A review of this literature suggests that there is no simple explanation that appears adequate in all cases. As a consequence, an eclectic approach seems most appropriate. Investigating and understanding these factors will provide the basis for developing appropriate treatment strategies.

Earlier attempts to explain chemical dependency were predominantly based on the moral model. This model promotes the belief that chemical dependency is the result of individual weakness. It suggests that the individual may overcome dependency via motivational changes and by strengthening one's moral character (Marlatt & Gordon, 1985). Although more contemporary approaches have supplanted this view within the drug treatment community, it is still widely held among significant segments of the general population (Crowe & Reeves, 1994).

The medical or biological model of chemical dependency, which is promoted by groups such as Alcoholics Anonymous and Narcotics Anonymous, has gained support as scientific studies of genetics and brain chemistry have evolved (Crowe & Reeves, 1994; Marlatt & Gordon, 1985). This view maintains that there is a genetic predisposition for dependency. Crowe & Reeves (1994) state that findings from longitudinal studies have uncovered a genetic link of alcohol dependency across multiple generations of families. This research implies a hereditary etiology and suggests that regardless of moral constitution or social and psychological factors a person with a predisposition to alcoholism will progress to dependency if they begin using alcohol. Although a similar assumption is often made about other drugs of abuse, Crowe & Reeves (1994) note that research evidence is much more difficult to obtain.

Other points of focus in the medical/biological model address the issue of brain chemistry and brain reward mechanisms. It has been argued (Suhl, 1998) that most substances of abuse cause short increases in EEG Alpha activity immediately following intake and absorption. According to Suhl, most people experience this brain state as desirable. He also suggests that following a drug/alcohol use episode the brain is unable to reproduce this desired effect and this predisposes the individual to re-abuse in pursuit of this pleasant state, and this may quickly develop into a chronic cycle (Suhl, 1998).

Additionally, it is argued that habitual substance use alters brain chemistry in such a way that the individual becomes progressively less capable of experiencing positive emotional states (Crowe & Reeves, 1994; Suhl, 1998). Consequently, the individual is driven to seek the short-term gratification of the abused substance and therefore, must maintain his or her drug and alcohol (or both) usage.

Psychological causes of chemical addiction are divided into two categories. On one hand are reinforcement processes that maintain the use of substances. On the other hand are personality trait factors that are associated with addiction (Crowe & Reeves, 1994). Basic behavioral theory suggests that a response, which is followed by a satisfying state of affairs, tends to be repeated (Thorndike, 1911). Crowe & Reeves (1994) argue that the substance abuser experiences this satisfying state in one of two ways. The positive reinforcement experienced by the substance abuser may come about from a drug's pharmacological effects, euphoria, or from other social rewards such as peer acceptance and increased self-esteem. In addition, the avoidance of pain serves as another reinforcing quality of substance use. For example, if using drugs or alcohol helps someone who is suffering from physical or emotional pain, their continued usage will be reinforced (Crowe & Reeves, 1994).

The notion of anticipatory goal responses (Hull, 1932) can be applied to the maintenance of substance abuse when viewing the cues associated with drug use. Drug cues as presented by Crowe & Reeves (1994) are those stimuli that are associated with a drug and its rewards. These include being around specific people, engaging in particular activities, or going to certain places. The presence of these cues will reinforce the terminal behavior, which in this case is the maintenance of substance use.

The psychological explanations of chemical dependency involving personality traits assume that substance abuse is linked to emotional problems and personal inadequacies. Some of the psychological characteristics associated with substance abuse include things such as low self-esteem, low self-confidence, low self-satisfaction, need for social approval, high anxiety, low assertiveness, greater rebelliousness, and self-regulatory deficiencies (Crowe & Reeves, 1994). As a result of the psychological suffering endured by individuals with these characteristics, substance abuse provides an escape and a means for survival.

There are several social causes of substance abuse presented in the literature on chemical dependency as well (Crowe & Reeves, 1994; Fisher & Harrison, 1993). An underlying factor to the social perspective is the influence of socialization. The four main socializing agents for the adolescent appear to be parents, peers, school, and the media (Crowe & Reeves, 1994; Gerbner, 1990; Gitlin, 1990; Zunz, 1997 [as cited in Norman et

al.1997]). When adolescents develop values that reinforce substance abuse, they are more likely to seek out other drug-involved individuals and subculture groups. This process of socialization can be viewed as the underlying current that runs through the different social perspective models.

Social learning theory (Bandura, 1977), which emphasizes the role of modeling and imitation in developing and maintaining behaviors, provides one explanation for substance abuse. This position maintains that individuals who are exposed to individuals or groups of people who model drug-related behaviors will learn to use and be rewarded for using substances (Bennett, 1983; Crowe & Reeves, 1994).

The subculture view of chemical dependency posits that there are several drug subcultures impacting on youth. These subcultures are established by a variety of groups. These groups may be based on a combination of variables including such things as ethnicity, age, school, or drug of choice. This view suggests that the current members of a subculture teach the new members how to use their drug, how to acquire it, and provide reinforcement for continued usage (Crowe & Reeves, 1994).

Other social factors that surround the issue of substance abuse reflect more of a sociopolitical stance. Numerous authors (Crowe & Reeves, 1994; Hawkins et al.1992) suggest that substance abuse is related to elements of poverty, racism, sexism, family dissolution, feelings of powerlessness, and alienation. Goode (1972) contends that individuals who are more attached to conventional society are less likely to engage in behaviors that are in opposition to societal norms and values. Apparently, those individuals who are detached from the dominant society are more likely to tolerate and/or engage in behaviors that are in opposition to the norm.

The development of the biopsychosocial model of substance abuse reflects an attempt to integrate and synthesize the previously described models. The premise of this model maintains that these other more narrowly focused views cannot adequately account for substance abuse across all individuals and all circumstances (see for example, Falk, 1994; Heather & Robertson, 1994). As such, the need for a wider more eclectic approach is necessary to comprehend the complex phenomenon associated with substance abuse. The significance in adopting this eclectic model can be found in its utility when matching appropriate treatment and prevention strategies to individual characteristics and needs (Brown, 1985; Hawkins, et al. 1992; Suhl, 1998).

In a national study on drug treatment in the U.S., Gerstein, Foote, & Ghadialy (1997) identify the most prevalent treatment settings in descending order as: drug treatment or rehabilitation facilities, self-help groups, hospital inpatient settings, physicians' offices, mental health centers, and hospital emergency departments. Relative to all the treatment settings reported, the 12-17 age group were most likely to use mental health centers and self-help groups. According to Gerstein et al. (1997), there were approximately 700,000 youth between the ages of 12-17 who were in need of treatment for substance abuse in the year 1992-93. The actual reported number of these youth who received treatment totaled approximately 125,000. This suggests that only about 18% of the estimated number of youth who required treatment for substance abuse during the year 1992-93 received such services. It is very significant to note that of all age groups reported in Gerstein et al.(1997) the age group that is least likely to receive services is the 12-17 year old group. Approximately 6-7% of the number of people in treatment were between the ages of 12-17. In proportion to the total estimated population in need of treatment in the 1992-93 sample, roughly 13.3% of them were 12-17 year olds.

When comparing treatment enrollment rates for type of drug, Gerstein et al. (1997) report that 12-17 year olds are more likely to be in treatment for marijuana than any other substance. These authors estimate that there were approximately 31,000 youth in 1993 who were in treatment for marijuana abuse as compared with approximately 10,500 for alcohol abuse. In addition, they report that approximately 27% of 12-17 year olds who have been in some form of treatment program are using drugs and/or alcohol again. It is important to note that in comparison to all other age groups, this age group had the highest reported relapse rates.

Predisposing Relapse Factors

Many addicts find recovery particularly difficult because the drug/alcohol dependency during developmental years may have delayed normal development, which makes it difficult for the recovering youth to function in an age- appropriate manner. Consequently, return back to substance use might be a way of managing the discomfort in adjusting to social milieu of youth. It has been suggested that there are a number of predisposing factors and precipitating events that are likely to trigger relapse in youth and adults. The predisposing factors in relapse include characteristics such as learning disabilities, dual or multiple diagnosis, high stress personalities, inadequate coping skills, absence of social support systems, dysfunctional families, and lack of impulse control. There are also a number of events in social and familial contexts that may amount to as upsetting situations and may

interfere with an individual's attempt to work through the recovery process. Such events are divorce or separation of parents, changing schools, relocation and loss of old friends, death of loved ones, breaking up of intimate relationships, and events such as loss of jobs.

Categories for Identifying Relapse-Prone Individuals

Gorsky and Miller (1986) made an attempt to classify individuals who were addicted to some substance based on their history of recovery and relapse history. According to commonly observed patterns of recovery and relapse, individuals primarily fall into three categories; recovery-prone individuals; briefly prone to relapse; or chronically prone to relapse. The relapse-prone youth and adults generally have been found to have three distinct characteristics. They seem to have difficulty in accepting the fact that they have addiction problems despite experiencing adverse consequences due to addiction. In other cases, the relapse-prone tendencies might be due to the failure of treatment in helping individuals with addictions to develop skills necessary for adhering to abstinence, and life style change. A third group of relapse-prone individuals often develops dysfunctional symptoms during the recovery process that lead them back to drug usage. Estimates are that about 40 to 60 percent of persons recovering from drug dependence exhibit relapse tendencies at least once following their first serious attempt at treatment. Among offenders, relapse has been found to accelerate the level of criminal activity (Peters, 1993). Lack of motivation to recover has often been thought as a potential cause for relapse. However, clinical experiences and research evidence do not provide sufficient documentation to support the strength of relationship between levels of motivation and ability to maintain abstinence (Gorsky et al.1986).

Relapse Prevention Techniques

The primary objective of relapse prevention treatment is to help recovering individuals/patients to develop abilities and skills to recognize relapse warning signs and maintain abstinence on their own. Although there are varied techniques that can be utilized for preventing relapse tendencies, there is a common set of principles that underlie most of the relapse prevention treatments. The following are the core principles that constitute the foundational elements of methods used to systematically teach recovering patients to recognize and manage relapse warning signs.

A. Self-Regulation and Stabilization: It is believed that as a client develops abilities and skills to self-regulate thinking, feeling, memory, judgement, and behaviors, the risk of relapse is likely to decrease (Gorsky et al.1993). The self-regulation is to be achieved through a systematic treatment plan for relapse-prone individuals to stabilize physically, socially, and psychologically. The objective is to help patients develop skills and abilities to perform basic activities of daily living. Since patients' level of stability may differ under low and high stress environments, the assessment of stability across varied environments is highly desirable. The stabilization process often involves detoxification from alcohol and drugs, managing interpersonal crises and stresses that are likely to threaten sobriety, learning skills to manage and identify addictive preoccupation, and structuring daily activities including exercise, eating habits, and contact with treatment personnel and self-help groups.

B. Self Assessment: It involves reconstruction of problems that may have caused the individual to seek treatment. The critical issues and warning signs triggering relapse are identified. In the self assessment process the focus is on the exploration of the sequence of events preceding relapse in order to recognize the fact that there are specific predictable events leading to relapse.

C. Understanding and Self-Knowledge: In order for an individual who has abused substances to minimize the possibilities of relapse, it is important for him/her to develop an understanding of the general factors that cause relapse. A typical procedure for enhancing understanding is to provide systematic and structured education about recovery, relapses, and relapse prevention planning strategies. The information that is provided to individuals who relapse by counselors and therapists generally includes knowledge of medical, clinical, and social models of addictive disease, common "stuck points" in recovery, warning signs identification, management of relapse warning signs, and effective recovery planning. Specific techniques can involve helping individuals with substance abuse problems develop a personal warning sign list and analyze warning signs by identifying irrational thoughts, unmanageable feelings, and self-defense behaviors.

D. Relapse Education: Relapse prevention education involves helping individuals with addictions who may potentially relapse learn specific strategies and skills such as self monitoring, self assessment, and self awareness of risk factors and warning signs. This is generally achieved by a six-step educational process which includes the following:

1. Self-knowledge and identification of warning signs. The objective of this process is to teach individuals with addiction problems to identify the sequence of events and problems that have contributed to their drug and alcohol abuse in the past and then to develop a list of circumstances that could cause them to relapse.
2. Change and recovery planning: This process teaches relapse-prone individuals to recognize, manage, and cope with warning signs as they occur.
3. Change and recovery planning: This involves the development of a schedule of recovery activities that will help the individuals recognize and manage warning signs when encountered in sobriety.
4. Awareness and inventory training: The training is intended to teach relapse-prone individuals to complete daily inventories designed to monitor compliance with the recovery program and check for the development of relapse warning signs.
5. Significant others and involvement of others: The help and support of others is of paramount importance to relapse-prone individuals during the process of recovery. Treatment programs should actively seek the involvement of family members, supportive peers, and 12-step sponsors in the recovery.
6. Maintenance and relapse prevention plan updating: An effective relapse prevention program requires an ongoing continued reinforcement of some type of therapy or treatment. It has been observed that even highly effective short-term treatment programs are often unable to interrupt long-term relapse cycles without continued delivery of therapeutic services and support to clients. Therefore, it is essential to plan and implement counselor-client update sessions that involve
    (a) assessment of initially developed warning sign lists, management strategies, and recovery plans;
    (b) reviewing issues and problems that are significant to maintain continued progress;
    (c) revising relapse warning sign list and incorporating new warning signs that may have developed after the previous update;
    (d) identifying new management strategies for newly developed warning signs; and
    (e) revising recovery plans to add activities necessary for managing new warning signs and eliminating those that are no longer needed.

Relapse Prevention Strategies

Utilizing the principles mentioned above, Marlatt & Gordon (1985) developed a relapse prevention paradigm that incorporates procedures for utilizing specific and global intervention strategies. The underlying assumption in this paradigm suggests that relapse is a normal part of recovery and as such; should be used as an opportunity for growth and development.

The use of self-regulation or self-monitoring strategies in relapse prevention serves as both an assessment procedure as well as an intervention technique (Lewis, Dana, & Blevins, 1994). In this procedure, the client keeps a written account of when, where, and why they want to use drugs or alcohol. They document both their feelings and the coping skills used to avoid or limit the amount consumed. This provides the client with a higher level of awareness of their urges to use and their level of competency in applying coping skills. According to Marlatt & Gordon (1985), increasing awareness is very effective in dehabitualizing the substance-use response. In addition, this allows the counselor to assess the individual's cues for substance use and the client's efficacy in implementing coping skills.

Another self-assessment technique is known as the direct-observation method (Lewis et. al.1994). Clients are asked to rate themselves in different social scenarios in terms of the degree of temptation to use and their level of confidence in their capacity to avoid a slip or relapse. The Situational Confidence Questionnaire (Annis, 1982) was developed to facilitate the identification of high-risk situations. This questionnaire allows the client to increase awareness about high-risk situations and allows the counselor to determine their client's coping skill level. In addition, it has been demonstrated (Kirisci & Howard, 1997) that this instrument is

appropriate without modifications for use with adolescents.

Coping skills and stress management techniques have also been found essential for an effective relapse prevention program. Once high-risk situations have been identified, the client can learn how to manage and deal with specific stress situations in an effective manner. Many relapse prevention programs focus on the technique of avoidance as an effective coping skill. There are situations in which individuals with substance abuse problems may simply have to learn avoidance behaviors. However, there are other situations which necessitate the use of systematic relaxation techniques, assertiveness, and effective communication skills to avoid recurrence of substance abuse.

Lewis, et al.(1994) list several specific stress management techniques that are effective in relapse prevention. These include the following cognitive and behavioral components:

(1) taking one thing at a time;
(2) working tension off physically;
(3) learning not to be a perfectionist;
(4) using humor;
(5) seeking outside help when needed;
(6) allowing time alone;
(7) adopting hobbies and activities that do not involve substance use;
(8) striving for moderation, as opposed to rigidity, in thought and action;
(9) sleeping and eating correctly; and
(10) balancing the costs and benefits of life.

The use of efficacy enhancement tools such as imagery or a decision matrix is another important component that has been employed in relapse prevention programs. Imagery in such approaches is used as relapse rehearsal, where the client imagines the successful use of coping skills in high-risk situations. The decision matrix is a form used to list the immediate and delayed positive and negative consequences of quitting or continuing the substance abuse behaviors. The recording of potential positive and negative consequences in a decision matrix is another type of self-assessment instrument, which has been found useful for both the client and the counselor.

The use of behavioral contracts has also been helpful in preventing a return to pre-intervention levels of substance abuse (Lewis, et al. 1994; Miller, 1999). The behavioral contract is a technique to be applied when the client experiences a slip. In this technique, a contract is agreed upon by the client and counselor for the client to strictly follow a set of instructions in the event that a slip occurs. Such instructions may involve calling a counselor or sponsor, going to a support group meeting, calling friends, discussing relapse occurrences with treatment center authorities or physician, and talking with spouse, family, or significant others (Talbott & Martin, 1999). For example, the client may be instructed to carry a card containing such a list along with outlines of other specific coping skills including thoughts to be engaged in and numbers to be called (Lewis, et al. 1994).

In addition to the specific intervention techniques, Marlatt & Gordon (1985) suggest that there are global intervention strategies that are critical to support specific relapse prevention efforts. Balancing one's lifestyle is an example of a global intervention strategy, which assumes that imbalance in one's lifestyle manifests itself as stress and ultimately as frustration. Learning to balance one's lifestyle involves striking an equilibrium between work and recreation, good and bad times, happiness and sorrow, and pain and pleasure. Lewis et al. (1994) indicate that a client in recovery may sometimes become overwhelmed and obsessed with the numerous details that can present themselves in the recovery process. In order to overcome such feelings, a balance can be obtained by emphasizing the "good things" in life such as encouraging clients to involve themselves in leisure activities and non-stressful hobbies. In addition, therapeutic activities such as jogging, meditation, or art (see for example, O'Connell, 1991) combined with healthy eating and sleeping habits promote the type of balanced lifestyle necessary for preventing stress, frustration, and relapse.

Marlatt & Gordon (1985) acknowledge the fact that frustration in life frequently leads to a desire for indulgence. In addition, it is assumed that all individuals regardless of their level of lifestyle balance will encounter frustration. It is, therefore, necessary for client's to learn more adaptive indulgences which can be substituted for their prior maladaptive indulgence patterns (i.e., substance abuse). These can be developed with a counselor and may include very simple things such as going shopping, getting a massage, reading a book, taking a vacation, seeing a movie, or going for a walk. It is important to emphasize that these indulgences should be developed creatively and prior to a client's increased frustration level. The implementation of these indulgences can be applied as discussed in the section on behavioral contracts, where the client has a specific list of behaviors to follow under certain antecedent conditions.

Summary

Relapse prevention issues are critical to the determination of the success of any substance abuse treatment program. It should be understood that understanding the causes of relapse is not simple because relapse does not occur within a vacuum. There are numerous contributing factors and warning signs which may provide an indication that a client may have a high probability of returning to substance abuse. Development and use of successful relapse prevention strategies require that relapse be understood as not only a single event causing return to the pattern of substance abuse, but also as the process during which high-risk behaviors gradually develop prior to the client's resumption of substance abuse. In the process approach to understanding relapse, a client's frequent exposures to "high-risk situations" are likely the cause of relapse. Other factors such as physical or psychological reminders of past drug or alcohol use, desire to test personal control over drug and alcohol use, or both and frequent thoughts and desires to consume drugs and alcohol are potential causes for the development of relapse-prone tendencies.

Considering the multiplicity of factors (personal, familial, social, and attitudinal) contributing to relapse, successful prevention strategies require coordination and communication between various agencies and systems. The state and community treatment programs must work collaboratively to ensure that relapse prevention efforts are comprehensive and successful. In other words, drug prevention treatment centers alone cannot attain desirable prevention results unless successful systems coordination is implemented. A related issue is the enormity of individual variation in social and psychological characteristics of relapsers. As a consequence, the effectiveness of various relapse prevention treatment programs may not be sufficiently generalizable across different groups of substance abusers. This is an area where further research needs to be carried out for determining the efficacy and generalizability of prevention programs.

It is important to note that most prevention strategies for individuals with substance abuse problems have been developed and used with adult populations. Despite the fact that adolescents are particularly at higher risk for relapse because of their developmental stage, little empirical research has been carried out with this population. The importance of studying the youth group is critical because drug dependency may cause delays in normal development making it difficult for recovering youth to function in an age appropriate manner. Developmental delays may complicate the reintegration of youngsters who abuse substances into the social milieu of youth. Failure to make adequate social adjustment may cause their return to substance use as a mechanism to cope with these inabilities (Bell, 1990).

The aforementioned issues lead to four major conclusions with regard to the efficacy of relapse prevention programs. First, more controlled studies are needed to evaluate the long-term effectiveness of relapse prevention strategies with adolescents in reducing factors such as cravings and increasing their ability for self-assessment, monitoring, self-control, and maintenance of abstinence behaviors. Secondly, studies are also needed to examine the posttreatment predictors of relapse. In order to accomplish this, well-designed comparison groups must be utilized and treatment conditions must be sufficiently clarified so that replications and comparisons across studies can be made. Thirdly, there appears to be some confusion among researchers in defining the concept of relapse as utilized in studying the effectiveness of relapse prevention strategies. Some degree of consensus regarding standard definitions would enhance the comparability of studies. Finally, although there is a heightened awareness of the importance of relapse prevention, there is a substantial lack of coordinated attempts to deal with the problem of relapse among adolescents. Overall success of prevention programs will ultimately depend on a well-orchestrated coordination among families, schools, communities, treatment centers, support groups and social institutions.

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Preventing Adolescent Relapse: Concepts, Theories, and Techniques

Shitala P. Mishra & Robert A. Ressler

Rationale

Relapse is a process through which an addict develops inability to cope with life in sobriety. Maintaining posttreatment sobriety is a serious problem. The rates of relapse among drug and alcohol dependent adults and youth are very high. The estimates are that relapse rates range from 35% to 85%. The posttreatment abstinence or avoiding relapse is a challenging issue for the success of many drug intervention programs. Despite the fact that a number of drug and alcohol treatment programs have produced promising results in reducing drug usage, the maintenance of posttreatment gains, however, has been more difficult.

Overview

This lesson is intended to acquaint the reader with the concepts, theoretical background, and principles that can be applied in preventing relapse of drug and alcohol dependency. The information gained through the lessons and exercises develop a clear understanding of the fact that relapse is a process that starts slowly and builds in intensity. Relapse is to be understood as a typical occurrence in drug and alcohol dependency unless contributing factors, often called "trigger mechanisms" are understood and addressed by families, friends, and treatment providers. The knowledge and understanding of the relapsing nature of drug and alcohol dependency should be to help students and interested professionals develop, evaluate, and implement intervention programs for maintaining posttreatment success and uninterrupted recovery.

Objectives

1. To enhance the knowledge and awareness of the concept of relapse and relapse prevention.
2. To increase understanding of potential relapse triggers.
3. To gain an understanding of fundamental principles underlying relapse prevention treatment.
4. To gain knowledge and understanding of psychological development as it explains addiction, recovery, and relapse tendencies.
5. To develop skills essential for identifying and managing warning signs.
6. To develop skills in planning and implementing successful relapse prevention programs.

Activities

The following exercises are intended to help students enhance their learning about relapse prevention by focussed discussion of key concepts and salient issues in small group situations. The exercises are also to help students develop skills to identify factors contributing to relapse and develop skills in devising tasks and activities to deal with relapse prevention's issues. Individual exercises are linked to the objectives of the lesson.

Exercise 1 for Objective 1: Definitions and Concepts

1. Divide students in two groups and have each group define the concepts of drug dependency/addiction, treatment, recovery, and relapse. Then have one group consider the concept of relapse as a single event. Have the other group consider relapse as process of development over time. Both groups are to provide arguments in support of each view. Have both groups report the results of their discussion to the entire class.
2. Have two students role play in front of the entire class. One student plays the role of a client with an addiction problem who is at the recovery stage and the other of a relapse prevention counselor. The goal is to have the counselor conduct a counseling session to determine where the client is in the

recovery process, how motivated the client is to abstain from drug and alcohol use, and the thoughts and feelings that the client has about his/her tendency to return to using drugs and alcohol.

3. Have the class discuss and develop a list of possible reasons as to why clients might find it difficult to stay sober and clean after treatment.

Exercise II for Objective 2: Relapse Triggers

1. Ask a small group to identify, list, and discuss kind of things recovering patients are likely to do and not do in their attempt to abstain from drug or alcohol use. Ask another small group of students to identify the patterns that repeat themselves during periods of abstinence. The discussion in a small group is initiated regarding the causes of relapse. Ask the group to identify what suggestions for learning they would have for relapsing clients in order to focus their thinking on what they can do to change.
2. Ask students to identify problems that are likely to appear to cause clients to return to using drugs and alcohol after treatment. Ask them to think of situations like: problems with
    a) people,
    b) situations,
    c) thoughts and feelings,
    d) health and sickness.

Exercise III for Objective 3: Principles Underlying Prevention Treatment

1. Ask students to have small group discussion on principles (such as self-assessment, self-knowledge, coping skills, understanding and awareness, and the involvement of significant others in recovery) underlying relapse prevention strategies.
2. Ask students to develop a relapse education program using principles listed in number 1 such as self-knowledge and self-assessment, etc.
3. Ask students to develop an instrument to be used as pre-and post-test to measure the effectiveness of relapse prevention education sessions. The purpose of this test will be to test clients their understanding and retention of content used in relapse education program.
4. Select a commercially available film on a relapse prevention program for the class to observe. After watching the film, student should be asked to discuss the content of the film and to critically evaluate the overall effectiveness of the procedures used in the film for education and treatment of relapse.

Exercise IV for Objective 4: Developmental Theories

1. Ask students to select a theory of adolescent development and critically examine the aspects of development that can help identify relapse-prone personality traits.
2. Have small group discussion on the salient features of cognitive and vehavioral approaches that are used in relapse prevention therapies.
3. Have stydrebts develop a set of tasks and activitis that can be used in eduction of youth to avoid relapse. Ask students to link these activities to pertinent theoretical approached.

Exercise V for Objective 5: Identifying and Managing Warning Signs

1. Assign students tasks of developing warning sign identification process involving the education of clients for developing and reviewing personal relapse warning lists.
2. Have students develop a warning sign checklist that possibly can be used to predict relapse. This check or rating scale may contain items indicating things such as trouble remembering things, difficulty managing emotions, feeling of loneliness, denial of concerns, loneliness, daydreaming, etc.
3. Have students develop some procedures such as sentence completion measures to be used with clients to analyze and develop treatment procedures. Examples of such techniques will contain items such as "I know my recovery is in big trouble because....., My thoughts are....., and My feelings are....., etc."

Exercise VI for Objective 6: Prevention Program Planning

1. Assign students the task of preparing recovery plan sheets for the clients to use in avoiding relapse. This will consist of making a list of activities such as seeing counselor and talking to sponsor that the clients will carry out each day.
2. Have students prepare the content and procedures that will be used for giving a one day seminar to relapse prevention counselors.
3. Ask students to prepare a list of questions to be used for evaluating the implementation of the relapse prevention plan for a client. Following are examples of questions to ask the client:
    a) What risk situations did you encounter today?
    b) How do you think or feel about your encounter with the situation?
    c) How did you handle the risk situation?
    d) What warning signs did you have today?
    e) What is the most important thing in the plan that helped you cope with the stresses of the day?